

# OSAH FORM 1

This form is available online at <http://www.ganet.org/osah/form.html> or by telephone request at (404)657-2800.

<b>OSAH USE ONLY</b>	AGENCY CODE	CASE TYPE	DOCKET NUMBER	COUNTY	JUDGE
DOCKET NUMBER:	<b>MH</b>				

## MENTAL HEALTH PROGRAM (ALL MH EXCEPT CER, COC & DUIRISK)

Patient or Client's County of Residence Prior to admission of the Facility: \_\_\_\_\_

County In Which Facility is Located: \_\_\_\_\_

*THE CURRENT ORDER WILL EXPIRE ON \_\_\_\_\_ UNLESS A NEW ORDER EXTENDS THE PERIOD OF INVOLUNTARY TREATMENT OR HABILITATION.*

### SELECT ONE CASE TYPE:

<input type="checkbox"/> JLJR Juvenile extension of commitment hearing <b>DHR v J.R. et al.</b> <input type="checkbox"/> MIH Mentally ill extension of commitment hearing OCGA § 37-3-83 <input type="checkbox"/> MIR Mentally ill extension of commitment desk review OCGA § 37-3-83 <input type="checkbox"/> MRH Mentally retarded extension of habilitation hearing OCGA § 37-4-42	<input type="checkbox"/> MRR Mentally retarded extension of habilitation hearing OCGA § 37-4-42 <input type="checkbox"/> OUTPATH Outpatient extension of commitment hearing OCGA § 37-3-81.1, 37-3-83 and 37-3-93 specifically <input type="checkbox"/> OUTPATR Outpatient extension of commitment desk review OCGA § 37-3-81.1, 37-3-83 and 37-3-93 specifically <input type="checkbox"/> SA Substance abuse involuntary outpatient treatment
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☐ PATIENT (Mentally Ill)  
 ☐ CLIENT (Mentally Retarded)  
 ☐ JUVENILE  
 ☐ OUTPATIENT  
 ☐ SUBSTANCE ABUSE PARTY

NAME:		TREATING PHYSICIAN:		DOES PATIENT/CLIENT WANT AN ATTORNEY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
CLERK SHOULD INSERT FACILITY'S MAILING ADDRESS FOR THE PATIENT/CLIENT UNLESS SPECIFICALLY NOTED OTHERWISE:		COMMITTED TO DEPARTMENT ON : _____ BY: _____ (COUNTY/COURT)		IS PATIENT/CLIENT INDIGENT ACCORDING TO AGENCY REPORTS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
PRIMARY DIAGNOSIS:		SUGGESTED HEARING SITE		AMOUNT OF RESOURCES?	
GUARDIAN AD LITEM/ GUARDIAN/ ATTORNEY NAME:		TEL NO:		FAX NO:	
ADDRESS INCLUDING ZIP CODE:		GEORGIA BAR NO:		EMAIL:	
1st REPRESENTATIVE:		TEL NO:		FAX NO:	
CURRENT ADDRESS INCLUDING ZIP CODE:		RELATIONSHIP TO PATIENT OR CLIENT:		EMAIL:	
2nd REPRESENTATIVE:		TEL NO:		FAX NO:	
CURRENT ADDRESS INCLUDING ZIP CODE:		RELATIONSHIP TO PATIENT OR CLIENT:		EMAIL:	

### FACILITY

NAME OF FACILITY:		TEL NO:		FAX NO:	
		EMAIL:		EMAIL:	
CURRENT ADDRESS (Street, City, State, Zip Code):		NAME OF CONTACT PERSON:		CONTACT PERSON'S DIRECT TELEPHONE NUMBER:	
ATTORNEY NAME:		SUPERVISOR'S NAME:		SUPERVISOR'S DIRECT TELEPHONE NUMBER:	
ADDRESS INCLUDING ZIP CODE:		TEL NO:		FAX NO:	
		GEORGIA BAR NO:		EMAIL:	

### CHECK DOCUMENTS ATTACHED:

- ☐ Petition to Extend Involuntary Hospitalization/Continued Habilitation/Outpatient Commitment  
☐ Committee Report  
☐ Individualized Treatment Plan  
☐ Other: (please specify ) \_\_\_\_\_